DOCUMENT RESUME

ED 307 528 CG 021 689

AUTHOR Gagne, Cyndi
TITLE Integration of Substance Abuse Services in Community Health Center Settings: Problems and Resolutions.
INSTITUTION Maine Ambulatory Care Coalition, Augusta.
PUB DATE Apr 88
NOTE 15p.; Paper presented at the Annual Meeting of the National Council on Alcoholism (Arlington, VA, April 21-24, 1988).
PUB TYPE Reports - Descriptive (141) -- Speeches/Conference Papers (150)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS *Community Health Services; *Counseling Services; *Delivery Systems; *Drug Rehabilitation; Program Effectiveness; *Rehabilitation; *Substance Abuse

ABSTRACT

In Maine a program was initiated to integrate substance abuse services in community health center settings in order that more individuals and their families who are affected by chemical dependency could be reached and treated effectively. Integration was defined as the degree to which substance abuse services addressed the perceived community need for such services and how the services fit into the already existing health care system at each site. In all sites, the new service was perceived as an advantage, with the most frequently cited reason being the convenience of local service. The actual utilization of substance abuse services at any given health center was directly related to the amount of time services had been available, the number of hours the counselor was on site, and the amount of attention the new service had received in the community. Barriers to full integration of substance abuse services into community health services were time, space, and schedule conflicts; incentives to retain trained professionals; maintenance of client confidentiality; and cost/benefit to the health center and contracted substance abuse program in the provision of the service. The successful integration of substance abuse services within a community-based health care delivery system is dependent upon the continual, consistent commitment of all professional staff and boards involved. (ABL)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED307528

MAINE AMBULATORY CARE COALITION

INTEGRATION OF SUBSTANCE ABUSE SERVICES IN COMMUNITY HEALTH CENTER SETTINGS: PROBLEMS AND RESOLUTIONS

Cyndi Gagne, M.A.

PROBLEM/OPPORTUNITY

In 1986, the Office of Drug and Alcohol Prevention of the Maine Department of Human Services made funds from an increase in the Alcohol Premium Fund available for the delivery of substance abuse services in rural areas statewide. Working through a cooperative agreement between the Department of Human Services, the U.S. Public Health Services, Bureau of Health Care Delivery and Assistance and the Maine Ambulatory Care Coalition, an organization representing Maine's community health centers, a program was developed whereby substance abuse agencies would expand their services into Maine's more rural areas utilizing health centers as delivery sites. Requests for proposals were issued to substance abuse agencies calling for Memorandums of Agreement between these agencies and local health centers outlining their mutual commitment to and a mechanism for integration of the substance abuse services into the health center program.

In January 1987, prior to the actual award of grant funds, a conference was held to bring together representatives from health centers, substance abuse programs, O.A.D.A.P. and the Coalition to discuss potential barriers to integration and to share information on successful strategies from centers which had previous experience in implementing new services. Seventeen health center sites in nine counties were targeted as delivery sites and funds were awarded to four substance abuse programs to deliver the services. Memorandums of Agreement between the participating agencies and health centers were finalized whereby each site would receive one to five days of counselor time dedicated to therapy, in-service training

CG 021689

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)
This document has been reproduced as received from the person or organization originating it
Minor changes have been made to improve reproduction quality
Points of view or opinions stated in this document do not necessarily represent official OERI position or policy

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY
Bonnie Post
TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

2
BEST COPY AVAILABLE

of health center staff and community education on the disease of chemical dependency. The Memorandums of Agreement also defined the respective roles and responsibilities of the participating organizations in the areas of hiring and evaluating personnel, reimbursement for space and receptionist/ secretarial time and the distribution of revenues collected from providing the substance abuse treatment.

O.A.D.A.P. contracted with the Maine Ambulatory Care Coalition for assistance in evaluating the progress and level of integration of the new service and to provide technical assistance in problem solving and sharing information on successful strategies at each of the selected sites. Since the Coalition had no one currently on staff with expertise in the field of substance abuse, it subcontracted with the Kennebec Valley Regional Health Agency's Division of Substance Abuse Services to join the Coalition in developing an evaluation protocol and to make joint on-site visits to each of the participating centers.

The importance of this project rests on the magnitude of substance abuse within Maine. Maine is a predominantly rural state. Until very recently high unemployment, coupled with isolation imposed by long, harsh winters and social attitudes which encourage substance abuse during leisure time, resulted in a major chemical dependency problem statewide. The four hospital based treatment programs as well as the majority of outpatient services for substance abuse are located in the more urban areas of the state, leaving a large geographic area without adequate resources to combat a growing problem. Strict Operating Under the Influence laws which promulgate suspension of drivers license, evaluation/ education, and, when appropriate, referral to treatment, necessitated the development of a system whereby the mandated treatment could in fact be obtained.

By making evaluation and treatment services available through local community health centers which provide comprehensive primary health care, it was expected that more individuals and their families who are affected by chemical dependency could be reached and treated effectively. Community health centers which maintain high utilization rates were perceived as optimal sites for expanding substance abuse services into these geographically dispersed areas for other reasons as well. Local residents tend to use their health center to meet a wide range of health care needs. Since most sites are host to part-time specialists in podiatry, optometry and dentistry along with their usually full-time family practitioners, it was expected that a substance abuse specialist could be successfully assimilated into this system. The priority placed upon the full integration of substance abuse services within an already existing health care delivery system grew out of the belief that to meet community needs and for the service to be utilized, both the service and counselor providing it would have to become a part of the health care team and be perceived by the community as part of the health center facility.

METHODOLOGY

For evaluation purposes, integration was defined as the degree to which substance abuse services addressed the perceived community need for such services and how the services fit into the already existing health care system at each site. The methods utilized to elicit information concerning the level of integration included a written questionnaire, followed by on-site interviews at each of the participating health centers.

A written questionnaire comprised of open-ended questions, was developed and mailed to administrators, medical staff and substance abuse counselors at each site. The categories targeted for procurement of information included:

- Perception of utilization and adequacy of the current level of service in meeting the community need.
- Perceived advantages/disadvantages of the new service.
- Avenues of communication/consultation relevant to patient care between health center provider staff and the substance abuse counselors.
- On-site training needs pertinent to substance abuse and related issues.
- Knowledge of, and adherence to, Federal Confidentiality Regulations governing the treatment of substance abuse.
- Outreach and marketing activities related to community awareness of the disease and availability of treatment.
- Amount of actual service delivery, including mechanisms for referral.
- Satisfaction with current roles and responsibilities as outlined in the Memorandums of Agreement.

Responses to the questionnaire were analyzed individually in preparation for the on-site interviews. These interviews were conducted to generate discussion concerning successful strategies utilized in the implementation of the new service and to follow-up on problem issues identified in the responses to the questionnaire. Technical assistance was provided by the Coalition in cases where progress relevant to community awareness or integration of the service within a health center did not advance as quickly or smoothly as anticipated. At the majority of sites, a Coalition representative was able to meet with a combination of administrative, medical and counseling staff.

GENERAL FINDINGS AND IDENTIFIED PROBLEMS

From the information obtained from the completed questionnaires and that gathered during site visits, several generalizations may be stated concerning the status of substance abuse services after approximately one and a half years of operation in rural community health center settings. In all sites, the new service was overwhelmingly perceived as an advantage. The most frequently cited reason was the convenience locally based services affords the patient. That same convenience, however, raised questions concerning maintenance of confidentiality in settings where everyone is familiar with one another.

At all centers, some channel of communication concerning mutual patients of provider staff and the counselor have been devised. Due to time, space and scheduling restraints, communication tends to be informal, rather than at regularly scheduled meeting or consultation times.

These same time, space and scheduling restraints have made it difficult to disseminate information relevant to substance abuse and its treatment to health center medical staff. However, the providers and counselors interviewed reported that the level of provider knowledge of the disease of chemical dependency was adequate and appropriate referrals were being made.

The actual utilization of substance abuse services at any given health center was directly related to the amount of time services had been available, the number of hours the counselor was at the site and, in part, to the amount of attention the new service had received in the community. In locations where some amount of service had been established prior to the currently funded projects, the case load of patients was higher and has remained so. In communities where the services at the health center were networked to other substance abuse services, for example,

employee assistance programs, county jail projects or student assistance programs, there was an increase in service delivery at the health center.

In all but a few sites, there was a consensus that the current level of service was adequate to meet the community need. At a few centers it was thought that further community outreach activities would present problems, as the counselor's case load was full and could not handle more patients unless hours were increased at these sites.

Affected family members have far outnumbered primary patients in utilizing the service. Though this finding is not odd, given the role of denial in the disease process of chemical dependency, the finding does anticipate the major role intervention strategies based upon close cooperation and consultation of medical providers and counselors will have in the future success of the program. It is essential that physicians, physician assistants and counselors are all knowledgeable and comfortable working with families and friends of an abuser to confront the denial of the disease in the primary patient.

Training on substance abuse and related topics has been addressed in a variety of ways, including informal discussion, presentations to the boards of several centers and in-service training on confidentiality. As mentioned earlier, time, space and counselor availability have affected the amount of in-service training at many sites. Of the three project goals, to provide therapy, in-service training and community education, the provision of in-service education to health center staff is the area which has received the least amount of attention.

In all the centers, outreach and marketing activities of substance abuse services has been undertaken to develop a heightened community awareness of both the disease and the availability of local treatment services. In most instances,

health center staff and the counselor collaborated to identify and contact appropriate organizations for dissemination of information. Media, in the form of newspaper and health center newsletter articles, were utilized by almost all sites and the resulting referrals and utilization of the service suggests that such forms of marketing should be ongoing and not just one-time endeavors.

Generally, counselors working at health center offices receive no extra incentive, compensation or special recognition for their placement in these remote locations which require additional time and travel on their part. Several sites have experienced turnover in counselors in a relatively short time. Such turnover raises the question of whether there is a relationship between staff longevity at a site and the lack of compensation for the counselors traveling out to a health center.

The Memorandums of Agreement are working well in so far as most of the participating organizations are satisfied with staffing and reimbursement arrangements for rental of space and receptionist time. However, billing procedures and collection of revenue for the substance abuse services, especially for Medicaid patients, has caused problems at some sites. More will be said of this in the next section.

As of January 1988, approximately 1000 patients have received substance abuse services through their local community health center. The service is being utilized, the communities are aware of the service and the majority of medical providers are making appropriate referrals to on-site counselors. However, four major barriers can be identified as impeding the full integration of substance abuse services into community health center settings. There are:

- time, space and schedule conflicts which preclude opportunities for regular in-service training and consultation on mutual patients.

- incentives to retain trained professional counselors in positions too often perceived as low status and inconvenient to the practitioner.
- maintenance of client confidentiality in small, close-knit communities.
- cost/benefit to the health center and contracted substance abuse program in the provision of the service.

STRATEGIES FOR PROBLEM RESOLUTION

A. Time, Space, Schedule Conflicts vs. Regularly Scheduled Consultation and Training Meetings

Community health centers are extremely busy. Between the number of patients to be seen and schedule conflicts which result in medical providers and counselors seldom being present and/or free at the facility simultaneously, innovative means to communicate on mutual patients or to disseminate information must be devised. Several centers have found that consultation and follow-up on mutual patients can be ensured through use of regular patient charts to update providers on a patient's progress, and that notes or phone calls between medical providers and counselors are an adequate means to communicate when the two parties are unable to meet face-to-face.

At those sites where it is impossible for the health center staff to attend presentations on issues and topics relevant to chemical dependency, counselors are developing one to three page topic papers to disseminate information on the disease concept, confidentiality, the effect of substance abuse on the family, adult children of alcoholics and treatment options. In some centers, this same written mechanism is being utilized to reach a variety of community components as a form of outreach, marketing and education. Sharing of pertinent literature on substance

abuse in those centers which maintain medical libraries has proven to be yet another valuable means of increasing providers' knowledge base for diagnosis and referral purposes.

B. Incentives for Counselors

Twelve of the seventeen participating health centers have experienced turnover in counseling staff since the inception of the project in 1986. Though it is recognized that the field of substance abuse in general has a high staff turnover rate, in organizations that take measures to retain staff this problem is markedly decreased. It is particularly important both to a new project located in a rural setting and to a program represented by one individual that there be a continuity in personnel. Word of mouth marketing is paramount in small communities and simply does not occur if people do not have adequate time to become familiar with a provider.

Initially, substance abuse programs tended to place their less experienced and least credentialled staff in the health centers. This was due to a combination of resistance on the part of counselors with seniority to work in remote offices, and to the programs themselves needing to retain, at their main offices, the counselors who bring in the most in third party revenues.

Several substance abuse agencies involved in this project have realized the importance staff retention plays in the ultimate success of this particular program. Accordingly, measures such as differentials or higher pay scales for the satellite office counselor have been instituted. Attitudes, recognizing the value of what a counselor in an outlying location is accomplishing are beginning to surface. Realizing that these counselors are building a practice which calls for a variety of

skills in marketing, community development and an ability to interact with a multiple range of individuals and organizations is now looked at when job performance is evaluated and/or promotions and pay raises are being considered.

C. Maintenance of Confidentiality

Special measures are called for to ensure the confidentiality of individuals seeking substance abuse services. Particularly in small communities where most residents are familiar with one another, maintenance of confidentiality or even perception that it is maintained can determine whether the service is utilized. While health centers practice confidentiality with regards to patient care and record keeping, substance abuse calls for an even higher level, such as not even acknowledging whether a patient is at the facility. As a result, several of the participating sites have needed to take a close scrutiny of aspects such as the layout of the waiting room and reception area, privacy of incoming phone calls and the location of the counselor's office vis-a-vis other activities within the facility.

In instances where complete privacy could not be insured for phone conversations, answering machines have been installed, and the counselor is responsible for scheduling their own appointments. Systems have been adopted to insure that potential or existing patients know how to contact the counselor on days that he/she is not at the health center. In yet other instances, where feasible, counselors have been given offices with private entrances so that patients waiting to see other providers do not see who comes or goes from the counselor's office. The charts of all substance abuse patients are kept separately and under lock and key from other patient records. As a further precaution, only the counselor has access to these files.

D. Cost/Benefit of Substance Abuse Services to Participating Agencies

The manner in which the project is currently operated calls for a Memorandum of Agreement between an existing substance abuse program and a community health center which specifies the respective responsibilities in areas such as rent, reception and billing. Within all of these agreements, the substance abuse program is the recipient of the O.A.D.A.P. funds, employs the counselor and pays the health center an agreed upon amount for space rental, telephone and receptionist and usually an agreement on the disposition of fees collected is included. Though these areas have tended to work out in an equitable fashion for both the substance abuse programs and the health centers, billing for the actual service delivery has presented some major problems.

Most of the agreements called for the health center to bill and collect for all self-pay and third party insured patients, however, health centers were unable, under the current Maine Medicaid regulations, to bill Medicaid for substance abuse services. This responsibility fell to the substance abuse program. The agreements called for close tracking of all revenues with a predetermined split for revenues between the participating agencies.

Over time it was found that the majority of patients utilizing substance abuse services were either self-pay or Medicaid eligible. The time involved in the determination of Medicaid eligibility, which often meant a bill was submitted too late to meet deadlines imposed by Medicaid, resulted in a financial loss for both parties. Also it was felt by many of the health centers that billing was an important component to the integration of the service and bills should be mailed from the centers themselves.

During 1987, the Coalition and O.A.D.A.P. worked with the Bureau of Medical Services, which operates Maine's Medicaid program to devise a mechanism whereby community health centers could bill Medicaid directly for these substance abuse services without becoming certified as a substance abuse agency, a lengthy and, for many of these sites, an inappropriate process. It was agreed that O.A.D.A.P. would develop a satellite certification process for health centers which had O.A.D.A.P. approved Memorandums of Agreement with licensed substance abuse programs and this certification would allow them to bill Medicaid directly for the services delivered at their sites. The new regulations went into effect February 1, 1988 and recently the Aroostook Valley Health Center became the first certified satellite site. As the system is just beginning to be implemented, it will be some time before it is determined whether or not Medicaid revenue is actually collected in a more timely and efficient manner. The Memorandums of Agreement for 1988 are being renegotiated to specify the new billing arrangement and to determine equitable distributions of revenue to the participating organizations.

CONCLUSION

The successful integration of substance abuse services within a community based health care delivery system is dependent upon the continual, consistent commitment of all professional staff and boards involved. Upon these individuals rests the necessity and responsibility to collaborate, openly communicate and demonstrate a willingness to be flexible in identifying and resolving problems as a group. Recognizing this and actually putting these elements into practice is instrumental for substance abuse services to be well perceived and thus, received and utilized by the community at large.

We are very pleased with what has been accomplished throughout Maine in a very short time. The commitment by all involved and the willingness to identify and resolve problems has had a major impact on our ability to treat substance abuse effectively statewide. The Bureau of Health Care and Delivery Assistance has recognized these accomplishments and the importance of substance abuse services being accessible to rural populations and has lent their support by providing funds to the Coalition for continued technical assistance to the participating health centers. We look forward to these activities.

Table 1

Location of
Community Health Centers
participating in the
Rural Outpatient Substance
Abuse Program